




Contracting Guide



Agents are
the driving
force behind
our success.

We are United American.

Rosenthal Financial Services, LLC

1344 Meriwether St - Griffin, GA 30224

Phone 770-968-5757 – Fax 770-968-2657

Toll Free 1-877-968-5757

www.RealFastService.com

Contracting forms to build your relationship with
United American Insurance Company.

Need Additional Information?

- Agent Service Center - 800-925-7355
- AgencyService@torchmarkcorp.com



Page 2 of 21
UA Contracting Worksheet
A step by step guide to becoming a UA member of the UA Team!

Please note, if any of the required forms listed below are not complete when returned with your paperwork and fees, it will delay the time necessary to conclude the activation process.

Required for Corporate

Important Notice: United American Insurance only contracts with individuals or C corporations. Also, United American Insurance does not contract any corporations in the states of Florida, Georgia, and Kansas.

- ☐ **Corporation/Agency Data Sheet** (Pkt. Pg 4) - Complete, Sign, Date.
- ☐ **Sub Agent Agreement** (Pkt. Pg 5) - Sign, Date. Please include General Agent Information.
- ☐ **Independent Contractor's Agreement** - Print Corporate name on (Pkt. Pg 7), sign/date by designated Agent in lower right corner of (Pkt. Pg 10) (**must sign signature section above the dotted line**). **Return all pages.**
 - o **Advance Program (Optional Commission Loan Program)** - Elect to receive loans from the Company by checking yes and signing at the bottom of (Pkt. Pg 10) (**must also sign signature section below the dotted line to request advances**).
This feature is optional and subject to a pre-screening background approval.

Required for Individual

- ☐ **Independent Agent Contracting Data Sheet** (Pkt. Pg 6) Complete, Sign, Date.
 - o **NOTE: If Recruiting Agent writing number is not submitted with paperwork, the Recruiting Agent will not be included in the hierarchy**
- ☐ **Independent Contractor's Agreement** - Print Agent name on (Pkt. page 7), sign/date by designated Agent in lower right corner of (Pkt. Pg 10) (**must sign signature section above the dotted line**). **Return all pages.**
 - o **Advance Program (Optional Commission Loan Program)** - Elect to receive loans from the Company by checking yes and signing at the bottom of (Pkt. Pg 10) (**must also sign signature section below the dotted line to request advances**).
This feature is optional and subject to a pre-screening background approval.
- ☐ **PC Hierarchy Worksheet** – (Pkt. Pg 20) **must be completed by Recruiting Agent.**

Required for All

- ☐ **Business Associate Agreement "BAA"** (Pkt. Pg 11) - Print effective date and name on (Pkt. Pg 11), sign last page of agreement (Pkt. Pg 13). **Return all pages.**
- ☐ **EFT-Direct Deposit Form** (Pkt. Pg 14) - Complete form-include a voided check or bank letter.
- ☐ **W-9 Form** (Pkt. Pg 15) – Complete required information. **Return page 15.**
- ☐ **Check/Money Order Payable to United American or Credit Card Authorization Form** (Pkt. Pg 19) - Complete, Sign, Date. (If applicable-see introductory letter chart)
Please note, Fees may double in states where Corp/Agcy and Designated Agent are both required to hold state appointments as they will in Res state.
- ☐ **Submit Copy of CE Credits for Annuity products** – (See Annuity CE - State Requirement table next page).
- ☐ **Submit Copy of Agent's State License** – (Required for OK, NY appointment).

Return contracting paperwork to Regional Director or Recruiter:

See separate email attachment "Director-Recruiter & Map" for current contact information.

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1344 Meriwether St - Griffin, GA 30224
Phone 770-968-5757 – Fax 770-968-2657

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Processing Fee Chart

Determine your processing fees by finding the state(s) you wish to be appointed in below.

Please note that some states require an additional renewal fee, during the states designated renewal time frame, to be paid if it occurs in the same renewal period as the initial appointment.

*Appointment renews biannually according to birth month.

Note: Products are not available in all states

State	Renewal Month	Agent Resident	Agent Non-Resident	Corp Resident	Corp Non-Resident	Total Corp/Principal Agent Resident	Total Corp/Principal Agent Non-Resident
AL	Oct	\$30.00	\$30.00	\$30.00	\$30.00	\$60.00	\$60.00
CA	Aug	\$48.00	\$48.00	\$48.00	\$48.00	\$96.00	\$96.00
CT	Feb	\$20.00	\$20.00	\$20.00	\$20.00	\$40.00	\$40.00
DC	Jan	\$25.00	\$25.00	\$25.00	\$25.00	\$50.00	\$50.00
DE	Dec	\$25.00	\$25.00	Must sign override form *		\$25.00 + override form **	
*FL	Appointed Month	\$60.00	\$60.00+\$6.00 per county	No Corporations allowed		\$60.00	\$60.00+\$6.00 per county
GA	Oct	\$10.00	\$10.00	No Corporations allowed		\$10.00	\$10.00
IA	Oct	\$8.00	\$8.00	Must sign override form **		\$8.00 + override form **	
KS	Oct	\$5.00	\$5.00	No Corporations allowed		\$5.00	\$5.00
KY	Nov	\$40.00	\$50.00	\$100.00	\$120.00	\$140.00	\$170.00
LA	Nov	\$20.00	\$20.00	\$20.00	\$20.00	\$40.00	\$40.00
MA	April	\$75.00	\$75.00	\$75.00	\$75.00	\$150.00	\$150.00
ME	Nov	\$30.00	\$70.00	\$30.00	\$30.00	\$60.00	\$100.00
MI	Oct	\$5.00	\$5.00	\$5.00	\$5.00	\$10.00	\$10.00
MN	Sept	\$10.00	\$10.00	Must sign override form **		\$10.00 + override form **	
MS	Dec	\$25.00	\$25.00	\$0.00	\$0.00	\$25.00	\$25.00
NC	Nov	\$20.00 per line of authority		Must sign override form **		\$20.00 per line of authority + override form **	
ND	Jan	\$10.00	\$10.00	\$10.00	\$10.00	\$20.00	\$20.00
NE	Jan	\$11.00	\$11.00	Must sign override form **		\$11.00 + override form **	
NH	Dec	\$50.00	\$50.00	\$50.00	\$50.00	\$100.00	\$100.00
NJ	Feb	\$50.00	No Non Res appts	\$50.00	No Non Res appts	\$100.00	No Non Res appts
NM	Jan	\$20.00	\$20.00	\$0.00	\$0.00	\$20.00	\$20.00
NV	April	\$15.00	\$15.00	\$15.00	\$15.00	\$30.00	\$30.00
OH	April	\$25.00 per line of authority		\$25.00 per line of authority		\$50.00 per line of authority	
OK	Sept	\$30.00	\$30.00	\$30.00	\$30.00	\$60.00	\$60.00
PA	Oct	\$15.00	\$15.00	\$15.00	\$15.00	\$30.00	\$30.00
SC	June	\$0.00	\$0.00	Must sign override form **		Must sign override form **	
SD	Feb	\$10.00	\$20.00	\$10.00	\$20.00	\$20.00	\$40.00
TN	Aug	\$30.00	\$30.00	Must sign override form **		\$30.00 + override form **	
TX	Aug	\$10.00	\$10.00	\$10.00	\$10.00	\$20.00	\$20.00
VA	April	\$12.00	\$12.00	\$12.00	\$12.00	\$24.00	\$24.00
VT	March	\$60.00	\$60.00	Must sign override form **		\$60.00 + override form **	
WA	Jan	\$20.00	\$20.00	\$20.00	\$20.00	\$40.00	\$40.00
WI	Nov	\$16.00	\$50.00	\$0.00	\$0.00	\$16.00	\$50.00
WV	March	\$25.00	\$25.00	\$0.00	\$0.00	\$25.00	\$25.00
WY	Dec	\$30.00	\$30.00	\$30.00	\$30.00	\$60.00	\$60.00

No Fee in AK, AR, AZ, CO, HI, ID, IL, IN, MD, MO, MT, OR, RI, SC, UT ~processing fees as of 06-15-13

****Please contact your recruiter or Agency Services to obtain the override form**

UNITED AMERICAN INSURANCE COMPANY COMMISSION SCHEDULE LEVEL 03

The following commission rates shall apply:

Lead Contract

1U94

LEVEL 03

POLICY TYPE	PLANS	AGES	STATES	1st Year	Years 2-5	Year 6	Years 7+
Medicare Supplement Products *							
Ages 65 and over	A, B, C, D, F, G, MC48	65(+)	STD	12.00%	12.00%	12.00%	12.00%
		65(+)	IN	12.00%	12.00%	12.00%	12.00%
		65(+)	WA	6.00%	6.00%	6.00%	6.00%
		65(+)	WV	12.00%	12.00%	7.00%	7.00%
	HDF	65(+)	STD	12.00%	12.00%	12.00%	12.00%
		65(+)	WA	6.00%	6.00%	6.00%	6.00%
		65(+)	WV	12.00%	12.00%	7.00%	7.00%
		65(+)	WV	12.00%	12.00%	7.00%	7.00%
	K, L, N Attained Age	65-69	STD	19.00%	19.00%	19.00%	7.00%
		70-74	STD	14.00%	14.00%	14.00%	7.00%
		75+	STD	9.00%	9.00%	9.00%	7.00%
		65(+)	IN	12.00%	12.00%	12.00%	12.00%
		65-69	WV	19.00%	19.00%	7.00%	7.00%
		70-74	WV	14.00%	14.00%	7.00%	7.00%
		75+	WV	9.00%	9.00%	7.00%	7.00%
		65-69	STD	16.00%	16.00%	16.00%	7.00%
	K, L, N Issue Age	70-74	STD	14.00%	14.00%	14.00%	7.00%
		75+	STD	12.00%	12.00%	12.00%	7.00%
		65(+)	WA	6.00%	6.00%	6.00%	6.00%
		(-)65	STD	12.00%	12.00%	12.00%	12.00%
Disability (Underwritten)	A, B, C, D, F, G, MC48	(-)65	IN	12.00%	12.00%	12.00%	12.00%
		(-)65	KS	0.00%	0.00%	0.00%	0.00%
		(-)65	WA	6.00%	6.00%	6.00%	6.00%
		(-)65	WV	12.00%	12.00%	7.00%	7.00%
	HDF	(-)65	STD	12.00%	12.00%	12.00%	12.00%
		(-)65	KS	0.00%	0.00%	0.00%	0.00%
		(-)65	WA	6.00%	6.00%	6.00%	6.00%
		(-)65	WV	12.00%	12.00%	7.00%	7.00%
	K, L, N	(-)65	STD	12.00%	12.00%	12.00%	12.00%
		(-)65	KS	0.00%	0.00%	0.00%	0.00%
		(-)65	WA	6.00%	6.00%	6.00%	6.00%
		(-)65	WV	12.00%	12.00%	7.00%	7.00%
Disability (O/E, G/I, ESRD)**	A, B, C, D, F, G, MC48	(-)65	STD	0.00%	0.00%	0.00%	0.00%
		(-)65	AZ	5.00%	5.00%	5.00%	5.00%
		(-)65	FL	6.00%	6.00%	6.00%	6.00%
		(-)65	IN	12.00%	12.00%	12.00%	12.00%
	HDF	(-)65	CA, CO, IL, KS, ME, MO	12.00%	12.00%	12.00%	12.00%
		(-)65	STD	0.00%	0.00%	0.00%	0.00%
		(-)65	AZ	5.00%	5.00%	5.00%	5.00%
		(-)65	FL	6.00%	6.00%	6.00%	6.00%
	K, L, N	(-)65	CA, CO, IL, KS, ME, MO	12.00%	12.00%	12.00%	12.00%
		(-)65	STD	0.00%	0.00%	0.00%	0.00%
		(-)65	AZ	5.00%	5.00%	5.00%	5.00%
		(-)65	FL	6.00%	6.00%	6.00%	2.00%
		(-)65	IN	12.00%	12.00%	12.00%	12.00%
		(-)65	CA, CO, IL, KS	9.00%	9.00%	9.00%	7.00%
		(-)65	ME, MO	12.00%	12.00%	12.00%	7.00%

NOTE: All Products may not be available in your state. Standard Rates shall apply unless state specific rates are provided herein.

The above commission percentages constitute the total combined commissions which can be earned at this hierarchy level and all levels beneath it (i.e., any assigned agents who are lower in the hierarchy). Total commissions paid under this Schedule shall be reduced by the amount of any commissions paid or loaned by Company to such assigned agents for the same business.

Commissions will be 3% less when initial premium payment is made by credit/debit card. In addition, all subsequent commissions will be contingent on the method of initial premium payment.

The Company reserves the right to change the commissions at any time, however, any change shall apply from and after the effective date of such change on business produced after that date. The Company in its sole discretion will determine which products will be available for sale and may withdraw any products at any time.

The Company shall determine the commission on any policy which is determined to be an internal replacement or conversion of an existing Company policy, or policy of any Torchmark-affiliate, in accordance with applicable practices and procedures in use at such time. The foregoing may result in the reduction, or elimination altogether, of commissions otherwise payable hereunder.

All States, excluding Washington State Medicare Supplement Sales: The initial commission is calculated on the modal premium collected with the application. Remaining first year commissions are calculated on the first policy year premiums collected subsequent to issue. Second and subsequent years renewal commissions are calculated on premiums collected after the first policy year. Renewal commissions will be calculated on the premium in effect on issue date or the premium paid, whichever is lower. Premium increases implemented after policy issue will not be counted in the calculation of commissions.

Washington State Medicare Supplement Sales: The initial commission is calculated on the modal premium collected with the application. Remaining first year commissions are calculated on the first policy year premiums collected subsequent to issue. Second and subsequent years renewal commissions are calculated on premiums collected after the first policy year. Renewal commissions will be calculated based on collected premiums.

*Notwithstanding anything to the contrary herein, renewal commissions shall be 0% in policy years 7+ for Medicare Supplement policies issued on a Guaranteed Issue basis due to replacement of a Medicare Advantage policy, excluding any such policies sold in WA.

**Refers to Open Enrollment, Guaranteed Issue and End Stage Renal Disease.

Commissions will not be paid on any portion of the premium charged for Medicare Supplement policies that is attributable to coverage for the Medicare Part B Deductible.

No commissions will be paid in association with Reserve Fund Annuity sales. Commissions will not be paid on any fees charged for a non-insurance program or service.

This Commission Schedule is subject to any change required by federal or state law or regulation.

This Commission Schedule shall be effective October 1, 2010

Rev 05-16-11 tw



UA Contracting Worksheet

A step by step guide to becoming a UA member of the UA Team!

Please refer to your introductory letter for any applicable fees.

Non Resident States

Other than your resident state, please list any additional non-resident states where you currently hold a license and would like to be appointed. One fee check may be submitted for applicable resident and non resident fees.

Return Fee Memo

If your completed contracting paperwork will be returned by fax or email, use this form to forward any fees due for a quick match up of your payment and paperwork once received at our office.

Attach a check or money order payable to United American; fill in the information below, and mail to UA Agent Licensing, P O Box 8080, McKinney, TX 75070.

Agent Name: _____
Social Security Number: _____
Phone Number: _____
Email Address: _____
Date: _____

ATTACH PAYMENT HERE

Please do not include copy of paperwork if previously faxed or emailed.

Please contact your Department of Insurance with any questions regarding this requirement.

Annuity CE - State Requirement		
Completion of CE Credit Hours prior to the Sale of Annuity Product		
Alaska	Indiana	Rhode Island
California	Kentucky	South Carolina
Colorado	Louisiana	South Dakota
Connecticut	Maryland	Texas
District of Columbia	Nebraska	Washington
Florida	New Jersey	Wisconsin
Hawaii	North Dakota	West Virginia
Idaho	Ohio	
Iowa	Oklahoma	
Illinois	Oregon	
As of 04-22-2013		



Corporation/Agency-Data Sheet ~ Recruiting Agent Writing # 90361

NOTE: If Recruiting Agent writing number is not submitted with paperwork, the Recruiting Agent will not be included in the hierarchy

Important Notice

This form is for Corp/Agcy and Designated Agent and should not be used for Independent Agents refer to enclosed Independent Agent Contracting Data Sheet.

United American Insurance only contracts with individuals or C corporations. Also, United American Insurance does not contract any corporations in the states of Florida, Georgia and Kansas.

Corp/Agcy Information

Full Name:

Tax ID Number:

Corp/Agcy Address

Address:

Suite #:

City:

State:

ZIP Code:

Phone:

Fax:

Mobile:

E-Mail Address:

By providing an email address, I authorize the company to communicate with me via email for all company correspondence.

Designated Agent Information

Full Name:

SS#

Address:

City:

State:

ZIP Code:

Phone:

Fax:

Mobile:

E-Mail Address:

By providing an email address, I authorize the company to communicate with me via email for all company correspondence.

Additional Information

Date of Birth:

Place of Birth:

Are you a citizen of the United States?

☐ Yes

☐ No

Information required by State Insurance Departments

Have you ever been convicted of a felony? ☐ Yes ☐ No (if so, enclose court documents and an explanation)

Have you ever been refused, had suspended, or revoked an insurance license in any state? ☐ Yes ☐ No

Do you owe an unpaid balance to any insurance company? ☐ Yes ☐ No (if so, enclose particulars)

Authorization to Obtain Information

I certify that my answers are true and complete to the best of my knowledge.

I AUTHORIZE ANY CONSUMER REPORTING AGENCY, or any other organization, or person having knowledge of my character, reputation and financial position to give United American Insurance Company any and all such information. I understand that the information obtained by use of this authorization will be used by the Company to determine eligibility for agent appointments, and for other business purposes in connection with our relationship. I hereby release them from all liability for any damage that may ensue from furnishing this information.

I give my consent to United American Insurance Company to perform periodic criminal history background checks in any state, including Georgia, prior to, and up to, termination of my contract with United American.

I understand that any information obtained will not be released by United American Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with this application.

I know that I may request to receive a copy of this authorization and the report. I understand and agree that a photographic copy of this Authorization shall be valid as the original.

Date **X** _____

X _____

SIGNATURE OF DESIGNATED AGENT



Sub Agent Agreement – must be signed by Designated Agent

To: United American:

I understand that United American Insurance Company does not compensate Sub-Agents, that after I have become authorized to represent the Company, I may place business for the Company only through the Direct Contracted Agent (person or corporation) of the Company for whom I am designated as sub-Agent, that such Direct Contracted Agent alone will be accountable to me for my compensation in accordance with the contract or agreement that I have with such Direct Contracted Agent, and that the Direct Contracted Agent is not authorized to and cannot bind or obligate the company for my compensation or for the performance of any contract or agreement which such Direct Contracted Agent may have with me.

I understand that United American Insurance Company prohibits solicitation of business by anyone who is not authorized to represent the Company by the Insurance Department of the jurisdiction in which the solicitation takes place, and I agree that I will not solicit for the Company until my authority to represent the Company has been secure from the applicable Insurance Department and is in my personal possession.

X _____
(Corp/Agency Name)

X _____
(Designated Agent Signature)

_____
(Corp/Agency UA Acct #)

X _____
Date



Independent Agent Contracting Data Sheet – Recruiting Agent Writing # 90361

NOTE: If Recruiting Agent writing number is not submitted with paperwork, the Recruiting Agent will not be included in the hierarchy.

Important Notice: *This form is for an Independent Agent and should not be used for Corporation/Designated Agents refer to enclosed Corporation/Agency Data Sheet.*

Applicant Information – Print Name

Full Name:	Social Security Number:
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Top Agent or Agency

Full Name:	UA Account Number:
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Business Address

Address:	Suite #:
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City:	State:	ZIP Code:
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Phone:	Fax:	Mobile:
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E-Mail Address:

By providing an email address, I authorize the company to communicate with me via email for all company correspondence.

Personal Address

Address:

City:	State:	ZIP Code:
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Phone:	Fax:	Mobile:
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E-Mail Address:

By providing an email address, I authorize the company to communicate with me via email for all company correspondence.

Additional Information

Date of Birth:	Place of Birth:
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Are you a citizen of the United States? ☐ Yes ☐ No

Information required by State Insurance Departments

Have you ever been convicted of a felony? ☐ Yes ☐ No (if so, enclose court documents and an explanation)

Have you ever been refused, had suspended, or revoked an insurance license in any state? ☐ Yes ☐ No

Do you owe an unpaid balance to any insurance company? ☐ Yes ☐ No (if so, enclose particulars)

Authorization to Obtain Information

I certify that my answers are true and complete to the best of my knowledge.

I AUTHORIZE ANY CONSUMER REPORTING AGENCY, or any other organization, or person having knowledge of my character, reputation and financial position to give United American Insurance Company any and all such information. I understand that the information obtained by use of this authorization will be used by the Company to determine eligibility for agent appointments, and for other business purposes in connection with our relationship. I hereby release them from all liability for any damage that may ensue from furnishing this information.

I give my consent to United American Insurance Company to perform periodic criminal history background checks in any state, including Georgia, prior to, and up to, termination of my contract with United American.

I understand that any information obtained will not be released by United American Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with this application.

I know that I may request to receive a copy of this authorization and the report. I understand and agree that a photographic copy of this Authorization shall be valid as the original.

Date X X

SIGNATURE OF APPLICANT

**UNITED AMERICAN INSURANCE COMPANY
GENERAL AGENCY DIVISION
INDEPENDENT CONTRACTOR'S AGREEMENT**

This Contract, and the Commission Schedule(s) attached hereto and made a part hereof for all purposes (collectively referred to as "this Contract"), is made by and between **UNITED AMERICAN INSURANCE COMPANY** (hereinafter referred to as "Company"), and _____ (hereinafter

(enter Name of Independent Contractor)

referred to as "Independent Contractor") for the purpose of soliciting applications for insurance and insurance products written under the General Agency Division, which provides for the sale of life and health insurance products.

RELATIONSHIP OF PARTIES

It is expressly agreed that the relationship intended by this Contract between Company and Independent Contractor shall be that of an independent contractor relationship only, and that nothing contained herein shall be construed to create the relationship of employer and employee. This Contract or any benefit hereunder may not be assigned, transferred, or pledged by Independent Contractor, without Company's prior written consent.

MANNER OF CONDUCTING BUSINESS

Independent Contractor's clientele may be developed by him by any lawful means. Independent Contractor shall select his own hours and workdays and is under no obligation to account to Company for his time. Company may hold sales meetings to acquaint Independent Contractor with new products and sales techniques for the benefit of Independent Contractor. However, attendance at sales meetings will be optional and at the expense of Independent Contractor. Independent Contractor shall be free to exercise his own judgment as to the time, routine, place, method and manner he solicits insurance. Independent Contractor shall not solicit outside the jurisdiction for which he is licensed or contrary to the laws or insurance regulations of the states where he operates.

Company may from time to time make available to Independent Contractor supplies, leads, name lists, advertising matter and other material designed to assist Independent Contractor in soliciting business. All such material and other policyholder information, whether past, current or prospective, acquired by Independent Contractor shall remain the sole property of Company, shall not be duplicated and shall be returned to Company within five (5) days after the termination of this Contract.

EXPENSES

Independent Contractor shall be responsible for all expenses incurred in the production of insurance for Company. Independent Contractor shall at his own expense furnish his own means of transportation, office or place of business, advertisements, form letters, letterheads, circulars, and any other relevant expenses incurred in the solicitation of insurance for Company.

Independent Contractor shall be responsible to Company for all loss or damage arising from business done by and entrusted to him and shall indemnify and hold Company harmless from any and all expenses, costs, causes of action, loss or damages resulting from fraudulent or unauthorized acts or omissions of Independent Contractor and any agent(s) appointed by Company and assigned to Independent Contractor.

POWERS, DUTIES & RESPONSIBILITIES

During the continuance of this Contract:

- A. Independent Contractor has the authority to remit applications for insurance to Company for approval or rejection and to collect only the initial premium payments due on such applications.
- B. Independent Contractor may procure personally, or through agent(s) if applicable, applications for insurance underwritten by Company.
- C. When authorized by Company and subject to Company approval, Independent Contractor may recruit, train, and supervise agents.
- D. Independent Contractor shall have the duty of properly representing Company and developing his territory with diligence and in an ethical manner, and Independent Contractor agrees to conform to the rules, regulations, and practices of Company.
- E. Independent Contractor shall be responsible to Company for all monies and securities received by him for Company and shall hold such in trust separate from all other funds and securities, and promptly remit same to Company.
- F. Company reserves the right at any time to terminate the contract of any agent appointed by Company and assigned to Independent Contractor.
- G. Independent Contractor shall not insert or authorize the insertion of any advertising matter bearing Company's name in any email, written publication, on the internet, or on other social media sites, or issue or distribute, or authorize the issuance or

distribution of, any circular or paper on behalf of Company, without first submitting said advertising matter in writing to Company and receiving prior written approval of Company. In addition, Independent Contractor must obtain Company's approval prior to referencing Company's name or products in any television or radio transmission.

COMMISSIONS

Company agrees to pay to Independent Contractor commissions on business written by Independent Contractor or any agents assigned to him by Company on premiums actually received and earned by Company in accordance with the Commission Schedule(s) attached hereto. In the event Company shall, either during the continuance of this Contract or after its termination, refund premiums under any policy to an Insured, Independent Contractor shall immediately repay to Company the amount of any commission paid him or his agent(s) on the premium so refunded.

- A. All commissions shall be calculated only on premium actually received by Company. Commissions will be calculated only on those premiums paid by or on behalf of the insured. No commissions shall be paid on interest, or on premium waived or commuted by reason of death, disability or exercise of policy options.
- B. Company at any time while this Contract is in force or after its termination may set off against any claims by Independent Contractor for commission or other monies accruing to the account of Independent Contractor under the terms of this Contract any debts, liabilities or obligations of Independent Contractor to Company or its affiliates. Independent Contractor further agrees that any indebtedness now or hereafter owing to Company or its affiliates shall be secured by a first lien against the commissions or any other monies payable to Independent Contractor under this Contract and any other contract Independent Contractor may have with Company or its affiliates. If Independent Contractor has one or more agents assigned to him and any such agent loses his vesting and has a debit balance with Company at such time, then that agent's account, including the debit balance, will be incorporated into Independent Contractor's account with Company. Independent Contractor's account will be credited with commissions from and debited for all charges against such agent's account. However, upon paying such indebtedness to Company, Independent Contractor will be subrogated to Company's right of recovery against such agent and Company will, if requested, assign its rights in said indebtedness to Independent Contractor, without recourse or warranty. Notwithstanding the foregoing, Company reserves the right, in its sole discretion, to instead incorporate any such agent's account into the account of an intervening agent assigned to Independent Contractor. Nonetheless, Independent Contractor is ultimately responsible to Company for all indebtedness which any agent assigned to Independent Contractor owes to Company.
- C. All amounts owed to Company or its affiliates by Independent Contractor shall become due and payable immediately upon notice to Independent Contractor.
- D. The right to receive commission shall automatically terminate upon termination of this Contract except as provided herein. Payment of renewal commission upon termination of this Contract will be vested immediately, subject, however, to Company's right of set off as set forth in this Contract, the limitations and exceptions described below and the provisions of the Loan Agreement and Department sections of this Contract.

The right to receive vested renewal commissions, if any, shall immediately terminate without notice if:

- (1) This Contract is terminated for cause or for any violations of any of the provisions or agreements of this Contract.
 - (2) In any calendar year following termination the amount of vested renewal commissions paid under this Contract is less than \$500.00.
 - (3) Any debit balance is not repaid within 120 days after termination of this Contract.
- The provisions set forth in D(1), D(2), and D(3) above, giving rise to the termination of the right to receive vested renewal commissions, shall not apply to commissions derived from WA State Medicare Supplement business.

- E. At the option of Company, payment of commissions will be held in abeyance for 120 days (45 days for WA State Medicare Supplement business) after termination to determine the existence of any sums due Company which are to be set off against commissions.
- F. Termination of an agent assigned to Independent Contractor shall not affect the right, if any, of Independent Contractor to receive overwrite commission on the production of such terminated agent.

This Contract shall be terminated by the death of Independent Contractor, if an individual, and all eligible renewal commissions shall be then vested and payable to the surviving spouse. If there is no surviving spouse then such renewal commissions shall be paid to the Executors or Administrators of Independent Contractor's Estate.

Company reserves the right to alter, increase, decrease, modify or withdraw the Commission Schedule and/or Loan Agreement Provisions of this Contract at any time. However, any change shall apply from and after the effective date of such change on business produced after that date.

If Independent Contractor elects, Company may make periodic loans to Independent Contractor against future credited commissions on applications written and submitted to Company by Independent Contractor or any agents assigned to Independent Contractor. Such loans shall be made in lieu of payment of credited commissions as provided in the Commission Schedule.

- A. Such loan(s) shall be based on insurance premiums on production submitted on completed applications. The amount loaned shall be determined in the sole discretion of Company.
- B. Any loan proceeds shall be reduced by the amount of chargebacks to Independent Contractor's account from any source.

INDEBTEDNESS OF INDEPENDENT CONTRACTOR

Any indebtedness owed by Independent Contractor to Company shall be paid upon notice to Independent Contractor. In addition to the provisions of the "Department" paragraph below, all indebtedness of Independent Contractor to Company shall be secured by a first lien on any commissions or renewal commissions due or to become due Independent Contractor. Company may at any time offset against all commissions accrued or to accrue to Independent Contractor, any debt due from Independent Contractor to Company or its affiliates, whether now existing or hereafter arising. In the event any indebtedness is placed in the hands of a collection agent or attorney, or both, Company shall be entitled to recover reasonable collection and attorney's fees. Unless otherwise prohibited by law or regulation, such indebtedness shall include any amounts paid by Company to appoint and/or properly license Independent Contractor. In addition, in the event Independent Contractor's indebtedness to Company is completely discharged by any individual or entity to whom Independent Contractor is assigned, such individual or entity shall be subrogated to Company's right to recover the balance of such indebtedness from Independent Contractor, and may thereafter proceed directly against Independent Contractor without the joinder of Company.

INDEBTEDNESS OF AGENT

For the purposes of this paragraph, an "agent" shall be any individual or entity appointed with Company to solicit insurance on its behalf on whom Independent Contractor receives an overwrite commission, or who is assigned to Independent Contractor and becomes a part of Independent Contractor's hierarchy, irrespective of the number of levels of agents under Independent Contractor. Independent Contractor shall be fully responsible for any indebtedness (sometimes referred to as an "agent's debit balance") of an agent, and does hereby guarantee payment of any and all indebtedness of an agent. Independent Contractor hereby approves any advances or loans which Company makes to an agent assigned to Independent Contractor, and Company shall not be obligated to obtain Independent Contractor's approval of any specific loan or advance. If an agent's appointment with Company is terminated for any reason (whether by Company, the agent or by mutual agreement), Company shall give the departing agent a period of 120 days within which to pay any indebtedness to Company by direct payment, application of renewal commissions or a combination thereof. In the event such indebtedness has not been discharged in full at the expiration of that 120 day period, the agent's right, if any, to further renewal commissions from Company shall automatically terminate, and Independent Contractor shall be liable for and responsible to discharge such indebtedness just as though Independent Contractor had incurred such indebtedness directly. In such event, Company shall have the same rights and remedies to recover said indebtedness from Independent Contractor as set forth in the "Commissions" paragraph. Upon payment and discharge of said indebtedness in full, Independent Contractor shall be subrogated to Company's rights against the agent, and may proceed directly against the agent without the joinder of Company.

DEPARTMENT

Should Independent Contractor at any time, either before or after termination of this Contract, wrongfully withhold any funds belonging to any applicant for insurance, a policyholder, or Company; or should Independent Contractor induce any policyholder to lapse, relinquish or surrender a policy with Company; or should Independent Contractor be in default under, or fail to comply with any provision, covenant, representation or warranty contained in this Contract or any other Contract, or in any document or instrument related thereto, between Independent Contractor and Company; or should Independent Contractor fail to comply with any State insurance laws or regulations, or Federal laws or regulations under which he or it is licensed or is otherwise subject; then Independent Contractor shall immediately forfeit his right to receive any commissions or any other compensation due or to become due, whether vested or otherwise, under this Contract or any other agreement with Company. The provisions of this Paragraph shall not apply to commissions derived from WA State Medicare Supplement business.

ADDITIONAL PROVISIONS

This Contract is personal and not transferable. Any assignment, transfer, or sale of this Contract or any right to interest herein, without prior written consent of Company, shall not be valid or in any way binding upon Company.

The use of the masculine gender shall include the feminine gender and the use of the singular shall include the plural where appropriate.

This Contract may be executed, electronically or manually, in counterparts, each of which shall be deemed an original but both of which together shall constitute one and the same instrument.

This Contract shall be effective as of the date both parties hereto have signed the Contract.

TERMINATION

This Contract may be terminated at the will of either party hereto, for any reason or without cause, at any time upon actual notice, written or oral. Cancellation or loss of license shall automatically terminate this Contract.

IN WITNESS WHEREOF, this Contract has been signed by the parties hereto.

UNITED AMERICAN INSURANCE COMPANY

X _____
Date

BY: _____
Chief Executive Officer

X _____
Date

X _____
Signature of Independent Contractor

Must complete below to elect to receive loans (advances)

Re: Loan Agreement:

- ☐ I DO elect to receive loans from Company.
- ☐ I DO NOT elect to receive loans from Company.

X _____
Date

X _____
Signature of Independent Contractor

Business Associate Agreement

This Agreement is made effective the ____ of ____, 20__, by and between United American Insurance Company, hereinafter referred to as "Covered Entity", and _____, hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information, and the "Health Information Technology for Economic and Clinical Health" ("HITECH") Act (Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5)) modified and amended the Administrative Simplification provisions; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Rules"), as further amended by the Omnibus Final Rule (78 Fed. Reg. 5566), (hereinafter, the Administrative Simplification provisions, HITECH, such rules, amendments, and modifications, including any that are subsequently adopted, will be collectively referred to as "HIPAA"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services and/or products to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined by HIPAA; and

WHEREAS, Business Associate may have access to Protected Health Information in fulfilling its responsibilities under such arrangement; and

WHEREAS, Covered Entity and Business Associate may have previously entered into a Business Associate Agreement, the Parties now wish to supersede such prior agreement with this Agreement;

THEREFORE, in consideration of the Parties' continuing obligations under the Arrangement Agreement, compliance with HIPAA, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties agree to the provisions of this Agreement in order to address the requirements of HIPAA and to protect the interests of both Parties.

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth by HIPAA. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of HIPAA, HIPAA shall control. Where provisions of this Agreement are different from those mandated by HIPAA, but are nonetheless permitted by HIPAA, the provisions of this Agreement shall control.

II. BUSINESS ASSOCIATE OBLIGATIONS

Business Associate acknowledges and agrees that all Protected Health Information that is created, maintained, transmitted or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate, or Protected Health Information which, on behalf of Covered Entity, is created, maintained, transmitted or received by Business Associate or a Subcontractor, shall be subject to this Agreement.

- (a) Business Associate agrees:
 - (i) it is aware of and will comply with all provisions of HIPAA that are directly applicable to business associates;
 - (ii) in the event it enters into an agreement with a Subcontractor under which Protected Health Information could or would be disclosed or made available to the Subcontractor, the Business

Associate will have in place an appropriate Business Associate Agreement with the Subcontractor before any Protected Health Information is disclosed or made available to the Subcontractor;

(iii) to use or disclose any Protected Health Information solely as would be permitted by HIPAA if such use or disclosure were made by Covered Entity: (1) for meeting its obligations as set forth in the Arrangement Agreement, or any other agreements between the Parties evidencing their business relationship, or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and HIPAA), or HIPAA. All such uses and disclosures shall be subject to the limits set forth in 45 CFR § 164.514 regarding limited data sets and 45 CFR § 164.502(b) regarding the minimum necessary requirements;

(iv) at the request of the Secretary, to comply with any investigations and compliance reviews, permit access to information, provide records and compliance reports, and cooperate with any complaints, pursuant to 45 CFR § 160.310;

(v) at termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy (and attest to the destruction of) all Protected Health Information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible;

(vi) to ensure that its Subcontractors to whom it provides Protected Health Information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity, agree to the same (or greater) restrictions and conditions that apply to Business Associate with respect to such information, and agrees to, pursuant to 45 CFR § 164.314, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity and ensure that any Subcontractors to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement;

(vii) Business Associate shall, following the discovery of a breach of unsecured Protected Health Information, as defined in HIPAA, notify Covered Entity of such breach pursuant to the terms of 45 CFR § 164.410 and cooperate in Covered Entity's breach analysis procedures, including risk assessment, if requested. A breach shall be treated as discovered by Business Associate as of the first day on which such breach is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate will provide such notification to Covered Entity without unreasonable delay and in no event later than ten (10) calendar days after discovery of the breach. Such notification will contain the elements required in 45 CFR § 164.410. Covered Entity shall determine any required actions with respect to any such breach, and Business Associate shall cooperate with Covered Entity and comply with such actions; and

(viii) Business Associate will not directly or indirectly receive remuneration in exchange for any Protected Health Information without a valid authorization from the applicable individual except in compliance with 45 CFR § 164.502(a)(5)(ii). Without written approval of Covered Entity, Business Associate will not engage in any communication which might be deemed to be "marketing" under HIPAA. In addition, Business Associate will, pursuant to HIPAA, comply with all applicable requirements of 45 CFR §§ 164.308, 164.310, 164.312 and 164.316.

(b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:

(i) if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:

(A) the disclosure is required by law; or

(B) Business Associate obtains satisfactory assurances through a written Business Associate Agreement from the Subcontractor to whom the information is disclosed that it will be

held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the Subcontractor, and the Subcontractor notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(ii) for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the Protected Health Information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

(c) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by HIPAA.

(d) The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to the use and disclosure of Protected Health Information to ensure Covered Entity's and Business Associate's compliance with the terms of HIPAA.

(e) Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware promptly and in the manner required by Covered Entity to permit compliance with the requirements of HIPAA. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

III. AVAILABILITY OF PHI

Business Associate agrees to comply with any requests for restrictions on certain disclosures of Protected Health Information pursuant to 45 CFR § 164.522 to which Covered Entity has agreed and of which Business Associate is notified by Covered Entity. Business Associate agrees to make available Protected Health Information to the extent and in the manner required by 45 CFR § 164.524. If Business Associate maintains Protected Health Information electronically, it agrees to make such Protected Health Information electronically available to the applicable individual. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of 45 CFR § 164.526. In addition, Business Associate agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by 45 CFR § 164.528. Business Associate and Covered Entity shall cooperate in providing any accounting required on a timely basis.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement, where practicable, Covered Entity shall give written notice to Business Associate of such belief within a reasonable time after forming such belief. If Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressly stated herein or in HIPAA, the Parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or

cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the Parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of Texas. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The Parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of HIPAA, such Party shall notify the other Party in writing. For a period of up to thirty days, the Parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with HIPAA, then either Party has the right to terminate upon written notice to the other Party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:

BUSINESS ASSOCIATE:

By: 

By: _____

Title: Senior Vice President and
Associate Counsel

Title: _____

United American Insurance Company

Electronic Funds Transfer – Direct Deposit

United American Insurance Company is now recommending that all Agents take advantage of this more convenient, safe, and efficient manner of receiving commission payments. No more checks to cash, no more worrying about lost or stolen checks, and in most cases, funds are available sooner than regular checks. Enrolling is as easy as 1-2-3. Simply complete the form below, attach a voided check, and return to our office by email to ALTECH@torchmarkcorp.com, fax to 972-569-3735, or mail to the attention of Agent Licensing at the address below.

→ **Please Note: You may receive one or more commission checks via mail while we are initiating the EFT process (subject to system limitations on EFT).**

United American Insurance Company Authorization Agreement for Direct Deposit

☐ New Agent

Important: This form will not be effective without a VOIDED check for the account indicated in Section 2 and form signed in Section 3 by the individual listed in Section 1.

ALL FIELDS MUST BE COMPLETED

☐ Set up EFT on ALL current and future agent accounts according to the information supplied below.

☐ ONLY set up EFT for those Agent Numbers listed below.

Agent Number	Agent Number	Agent Number	Agent Number	Agent Number
--------------	--------------	--------------	--------------	--------------

1

Name (please print)	SSN	Tax ID
---------------------	-----	--------

I hereby authorize United American Insurance Company to deposit directly into my account listed below. If the company erroneously deposits funds into my account, I authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited.

2

Depository Name	<input type="checkbox"/> Bank <input type="checkbox"/> Credit Union <input type="checkbox"/> Savings & Loan	City, State, Zip
Transit/ABA number	<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	Account Number

This authorization will remain in effect until cancelled by the company or the company has received written notification from me that it is to be terminated in such time and manner for the company to act on it.

3

Signature X	Date X
----------------	-----------

Request for Taxpayer Identification Number and Certification

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number										
				-				-		

Employer identification number										
				-						

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the

withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

**PC ADMINISTRATION
HIERARCHY WORKSHEET**

Page 21 of 21

Please print below, at each level, as applicable: Writing Level, Name and Writing number, if known.

	WRITING LEVEL	NAME	WRITING NUMBER
Level	05	Matthew G. Rosenthal	90361
Level	03		
Level			
Level			
Level			
Level			
Level			

MANAGING GENERAL AGENT

\$350,000 Min. Production Requirement/Agency Convention Qualifier

SUPERVISING GENERAL AGENT

\$150,000 Min. Production Requirement/Individual or Agency Convention Qualifier

GENERAL AGENT

\$100,000 Min. Production Requirement

All premiums are NAP. 18 months to qualify. "Eagles" Min. Production Requirement \$500,000 NAP Plus Convention Qualifier. 70% Persistency required for Convention and/or Level Upgrade.

BROKER AND AGENT LEVEL

No minimum production requirements

PLEASE CHECK ONE:

☒ NEW APPOINTMENT ☐ CORRECTION/CHANGE

Will the above named be participating in the advance loan program? Yes ☐ No ☐

FORM MUST BE DATED AND SIGNED BELOW BY THE MANAGING GENERAL AGENT.

☒
Signature

☒ Matthew G. Rosenthal
Print Name

☒
Date Signed

☒ 90361
Writing Number